

SUPPLEMENTAL QUESTIONNAIRE PUBLIC HEALTH NURSE II

NAME: _____

Social Security Number _____

Submit this supplement questionnaire together with your application form. Based on your responses to this application supplement, your job-related training and experience will be evaluated using a pre-determined formula. Scores from this evaluation will determine the applicant ranking and placement on the eligible list. Applications submitted without a completed supplemental questionnaire will not be considered.

NOTE: Resumes, letters, and other materials will not be evaluated or considered by the rating panel as responses to the items in the supplement.

INSTRUCTIONS: Mark an "X" in the box that corresponds with your training or experience.

	No Training/ No Experience	Received Training/ No Experience	6 – 11 months experience	1 – 2 years experience	More than 2 years experience
Consultation/Use of Assessment Tools					
Case Management/Health Supervision					
Monitoring Outcome/Patient Follow-Up					
Multi-Disciplinary Teamwork					
Creating/Implementing Care Plans/ Discharge Planning					
Interventions/Referrals					
Diabetes/Hypertension/Heart Disease					
Tobacco-Related Illness/Tuberculosis					
Developing Health Education Materials, Classes, Public Service Announcements					
Home Health Nursing					
School/Parish Nursing					
Obstetrical, Labor/Delivery, Postpartum Nursing					
Pediatric, Neonatal, Neonatal Intensive Care Nursing					
Infection Control/Epidemiology Nursing					

I certify that all the statements made in this application supplement are true, complete, and correct to the best of my knowledge and are made in good faith. I understand that any misrepresentation and/or falsification of my answers may result in my application being ineligible for this recruitment. My signature authorizes Placer County to make any appropriate investigations to verify information.

Signature of Applicant: _____

Date: _____